Simplifying the Administrative Work in Getting Paid

Presentation to:

DMHC Financial Solvency Standards Board

By: Nileen Verbeten, California Medical Association

August 9, 2008

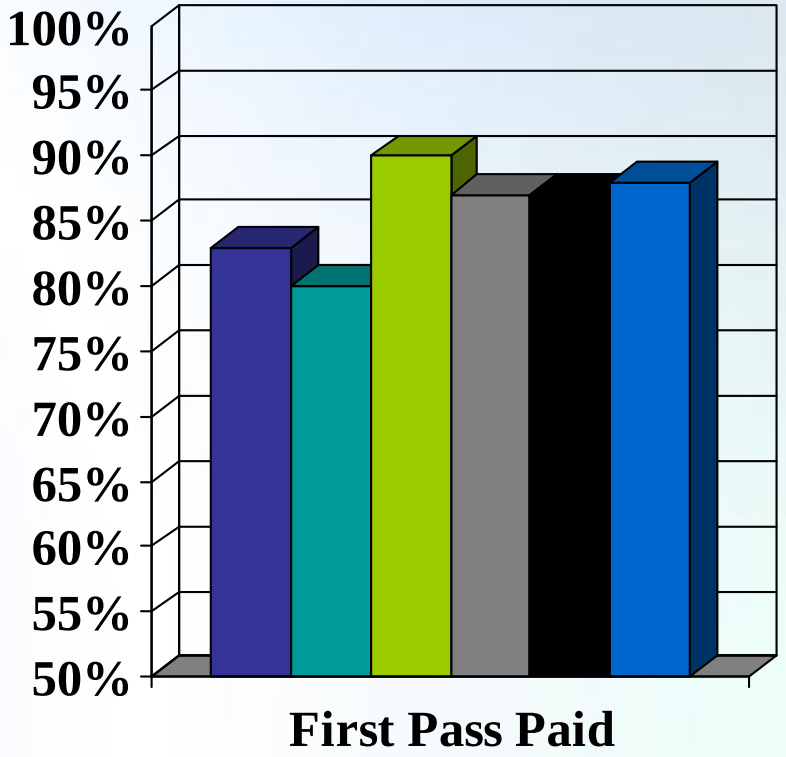
Revenue Cycle

- Scheduling: Schedule patient, **verify insurance information** and **obtain authorization**, if required
- Check-in/Check Out: Check patient in, **collect copayment and deductible**, if applicable
- Documentation and Coding: Document service, **assign codes, post charges** and prepare claim for submission
- Billing: **Submit clean claim** to correct payer and follow up
- Collections: **Pursue unpaid amounts**, bill secondary payer or patient as appropriate
- Payment Applications: **Correctly post payments, adjustments, refunds** to achieve a fully paid bill

Percent of Claims Paid on First Submission – Large California Payers

Best experience: the top six payers in California pay between 80 and 90 percent of clean claims the first time they are submitted. The remaining 10 – 20 percent require practice follow-up to obtain payment – sometimes multiple times.*

Achieved through optimal use of new technology and preaudit of claims for compliance with payor requirement variations before release.

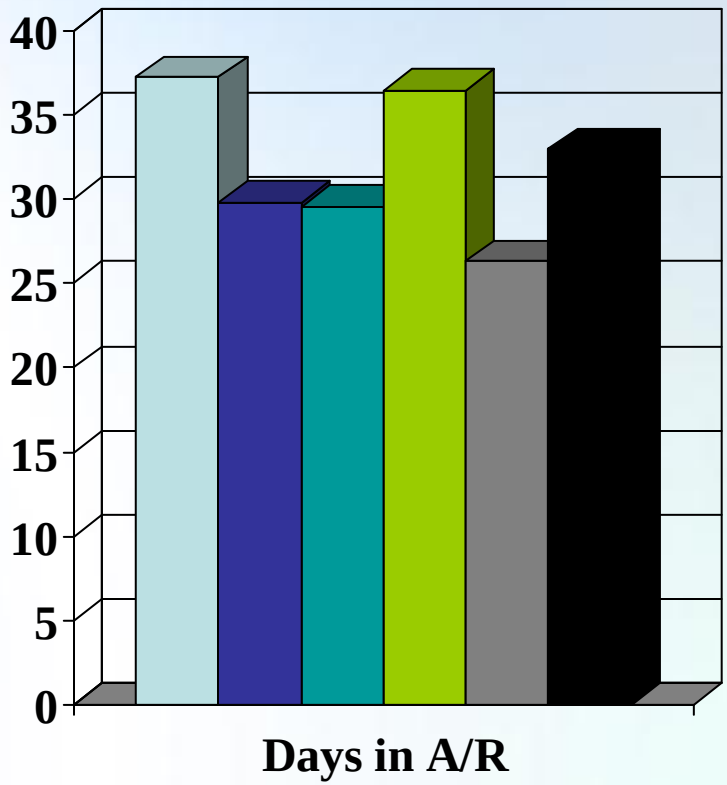


*Based on >13,000 claims, 4th quarter 2005

Best Experience in Days in A/R

Optimal experience (maximized use of EDI, for clean, pre-scrubbed claims, released immediately following service delivery) finds accounts receivable varies from 26 to 36 days for these six payors.

Most practice are twice this.



*Based on >13,000 claims, 4th quarter 2005

High Deductible Health Plans/ Consumer Directed Health Plans

Implications?

- Health Savings Accounts – money comes from bank account, not insurer
- Contractual allowable applies – based on negotiated rates and payment rules that vary by payer
- Bill patient after plan adjudication

Low reimbursement + high collection cost + delay in collection + high risk of non collection

Today' Practices: Eligibility Checking

- Best practice – PMIS automatically queries eligibility databases prior to office hours to confirm scheduled patients and stores results in patient record. Supports real-time e-query of individual patients. Also stores benefits summary and alerts if authorization is needed and flags any variation requiring attention.
- Average practice – staff log onto single clearinghouse or individual payor Websites to obtain eligibility and benefit information prior to start of day, prints copy for file and manually updates PMIS. POS machine used for Medi-Cal.
- Suboptimal practice – verification by phone at check in or later, reliance on patient presentation of card. Minimal technology aids for maintaining eligibility and benefits information.

Limitations of Present Databases

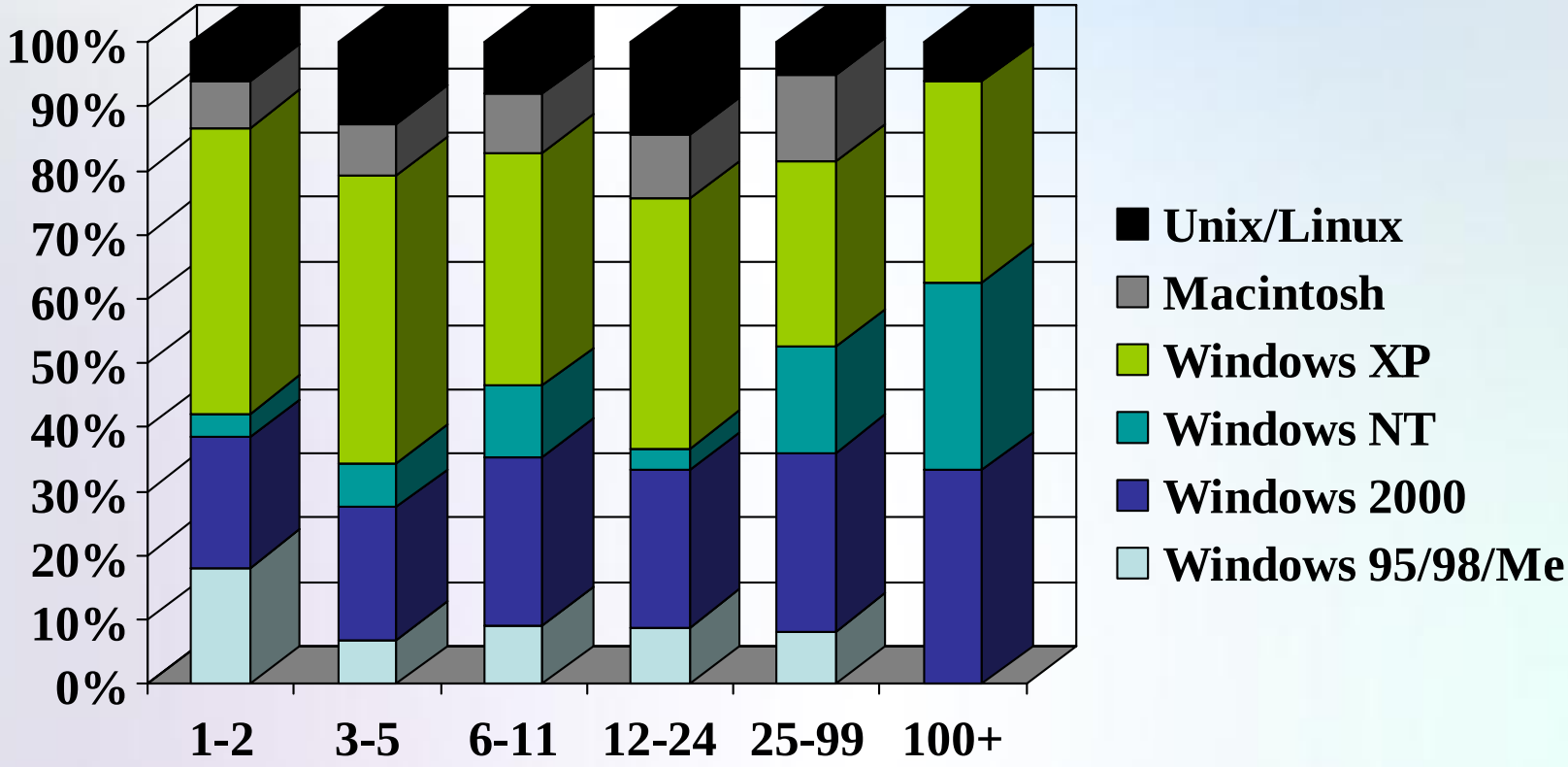
- Lack of database of eligibility/benefits for
  - Many PPOs
  - Medicare and other governmental programs
  - Workers' Comp
  - Most self insured plans
  - Many RBOs
- Varying rules
  - DOFR variations
  - Differing authorization requirements
- Payor security schema often difficult for practices – reducing value of Website
- Clearinghouse service variations

Getting Paid: Patient Responsibility

- What does the patient owe?
  - Contracted allowable (vary by payor and product line)
  - Payment rules (vary by payor and product line)
  - Benefit design (including deductible and copay/coinsurance) vary by payor by employer)
- Common: 15-20 or more payors/PPOs with multiple product lines.
- Currently payors with HCHP or CDHP products require collection to be delayed for claim adjudication.
- Poor financial risk for the practice.

Present Reality

Practice technology is older



Swipe Cards per Wikipedia

- A swipe card is a (typically) credit card size badge incorporating a magnetic stripe, an RFID tag, a transponder device and/or a microchip mostly used for business premises access control or electronic payment. Swipe cards in their strict sense need to be swiped through some kind of detector device to a sensor to be detected…

Implications for the Swipe Card in Physician Practices?

- Will it access real time adjudication?
- Will it trigger EFT?
- Can it be integrated into proper workflow or will it require double entry and paper capture and storage for proof?
- Will it require different devices for each payer?
- Who bears the cost of the devise(s)?
- What effort will be expended to integrate this new technology with new PMIS systems?